STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155571	B. WING		06/03/2011
		II		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8	ı	WEST 300 SOUTH	
MILLER'S	S MERRY MANOR			RK, IN47336	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This wish was f	an a Dagartification and	F0000	Dlagge accept the following Dla	n of
		or a Recertification and	F0000	Please accept the following Pla Correction as our Credible	111 01
	State Licensure	e Survey.		Allegation of Compliance.	
	Curvey detect			l Smith of Particular	
	Survey dates:			Corrective action will be comp	leted
	May 31, June 1, 2, 3, 2011.			by 7/3/11	
	Facility number: 000519			We respectfully request paper	
	Provider numb	er: 155571		compliance.	
	AIM number: 1	00287230			
	Survey team:				
	Delinda Easter	ly, RN TC			
	Betty Retherfor	-			
	Ginger McNam	-			
	Karen Lewis, R				
	Randy Fry, RN				
	Trailay 11y, 131				
	Census bed typ	ne.			
	SNF: 6				
	SNF/NF: 34				
	Total: 40				
	Total. 40				
	Census payor	tvne·			
	Medicare: 3	type.			
	Medicaid: 32				
	Other: 5				
	Total: 40				
	Stage 2 sample: 24				
	These deficien	cies also reflect State			
	findings cited i	n accordance with 410			
	IAC 16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DXGR11

Facility ID:

If continuation sheet

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 06/03	e survey pleted /2011
	PROVIDER OR SUPPLIER		11563 \	ADDRESS, CITY, STATE, ZIP C WEST 300 SOUTH RK, IN47336	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Quality review 2011 by Bev Fa	completed on June 8, aulkner, RN				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER S MERRY MANOR		<u></u>	STREET A	NDDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL I. SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
F0156 SS=B	The facility must in orally and in writing resident understar all rules and regular conduct and responsible facility. The far resident with the number of the facility. The far resident with the number of such influence of admission when the resident Medicaid of the ite included in nursing State plan and for be charged; those that the facility offer resident may be of charges for those resident when charand services speciand (B) of this second (B) of this second in the facility must in or at the time of activity of the facility in the facility i	Inform each resident before, and periodically the stay, of services solity and of charges for eluding any charges for ed under Medicare or by the em rate.		TAG	DEFICIENCY)		DATE

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		•	11563 V	NDDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	procedures for esi Medicaid, includin assessment unde determines the ex non-exempt resou institutionalization community spous resources which c available for paym institutionalized sp or her process of eligibility levels. A posting of name telephone number advocacy groups and certification a office, the State or protection and adv Medicaid fraud co that the resident in State survey and concerning reside misappropriation of facility, and non-or directives requirer The facility must or requirements spec of this chapter rela policies and proce directives. These provisions to infor information to all a the right to accept surgical treatment option, formulate a includes a written	and attributes to the ean equitable share of cannot be considered tent toward the cost of the couse's medical care in his spending down to Medicaid as, addresses, and as of all pertinent State client such as the State survey gency, the State licensure inbudsman program, the vocacy network, and the introl unit; and a statement may file a complaint with the certification agency in abuse, neglect, and of resident property in the compliance with the advance ments. Somply with the cified in subpart I of part 489 ated to maintaining written adures regarding advance requirements include in and provide written adult residents concerning or refuse medical or and, at the individual's an advance directive. This description of the facility's ent advance directives and					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155571	B. WING			06/03/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R.			VEST 300 SOUTH		
MILLER'	S MERRY MANOR			DUNKIF	RK, IN47336		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
	name, specialty, a physician response. The facility must proceed facility written information and use Medicare how to receive refrozered by such the A. Based on reinterview the face residents were information as coverage was were informed that could be in the lack of Medicare non-date for the lack of Medicare n	cord review and acility failed to ensure provided detailed to why Medicare being terminated and of possible charges acurred as a result of dicare coverage f 3 residents reviewed red notification of coverage. (Resident #'s record review and acility failed to ensure aware of their s for 3 of 4 sampled riewed for notification of the 24 residents ded in the Stage 2 ent Council President ts #29, and #26)	F0	156	F 156 It is the policy of Miller Merry Manor, Dunkirk to effectively inform residents of their rights, rules, and cost of services provided by the facil Residents #17, 22, and 24 affected by the deficient practice have not been covered by Medicare for over a year. All other residents having been covered by Medicare have the potential to be affected by the deficient practice. The Office Manager will sense letter no later then 48 hours of day of Medicare non-coverage those residents in the facility covered by Medicare. This lewill include: Detailed informates to why Medicare coverage terminated, Any charges the residents could be assessed result of Medicare cancellation and Facility rates that could be charged to the resident for non-covered services (Attachment #1). This correct action shall be on-going for a resident's who will no longer	f f f f f lity. tice d a of the ge for etter tion e was as a on, oe ctive all be	07/03/2011
	Findings includ	e:			covered under Medicare with	iin	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	OING	00	COMPL	ETED
		155571	B. WING			06/03/2	011
				STREET AL	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			11563 W	EST 300 SOUTH		
MILLER'S	S MERRY MANOR		I .		K, IN47336		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	+	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	Pi	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΈ	DATE
		,			our facility. The Office Manag	ner	
	A 4 \ Davienne	f the a UNI ation of			will be responsible for tracking		
	A. 1.) Review o				"Notice of Medicare Provider		
		der Non-Coverage			Non-Coverage Letters" using		
	letters for Resid	dent #'s 17, 22, and 24			Attachment #2. This tool will		
	on 6/2/11 at 2:3	30 p.m., indicated the			used indefinitely for any resid	dent's	
	letters lacked th	ne following			no longer being covered by		
	information,	5			Medicare. This will be review		
	,				in the monthly QA meeting.		
	a Detailed info	rmation as to why			of Compliance will be 7/3/11.		
	Medicare cover	•			Resident's #28, 29, and 26 w reeducated of resident rights		
		age was being			during the Resident Council		
	terminated.				Meeting held on 6/9/11. This	.	
					deficient practice had the	´	
	•	the residents could be			potential to affect all resident	t's in	
	assessed as a	result of Medicare			the facility. The resident righ		
	cancellation.				were reviewed with all reside	nts	
					in attendance of the Residen		
	c Facility rates	that could be charged			Council Meeting held on 6/9/	11	
	•	for non-covered			(Attachment #3). All other		
	services.	ioi non-covered			residents not in attendance v	vill be	
	Services.				re-educated by 7/3/11 on	, l	
					Resident Rights and quarterl thereafter. The Social Service		
	_	view with the Human			Director will be responsible for		
	Resource Mana	ager on 6/2/11 at 2:25			reviewing the Rights of the	j.	
	p.m., she indic	ated she had no			Residents and will be reflected	ed in	
	information to p	provide related to the			the Resident Council Meeting		
		g received any of the			Minutes every month .	-	
	above informat	~			The Social Service Quarterly		
	220.0				Assessment will be complete	-	
					the Social Service Director o	r	
					designee quarterly on all		
					resident's and will include documentation of resident rig	ahte	
					Also a posting will be placed		
					the Activity Calendar, which i		
					given to each resident and pe		
					within the facility, of where		
				residents can locate the Res	ident		
					Rights. Corrective action wi	II be	

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	A. BUILDING	00	COMPLETED 06/03/2011
	PROVIDER OR SUPPLIER		11563 \	ADDRESS, CITY, STATE, ZIP CODE WEST 300 SOUTH RK, IN47336	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				monitored utilizing the QA To "Resident Right Review" (Attachment # 4). This will It completed monthly for the numerite months then quarterly there by the Social Service Direct designee. Results of the au will be reviewed in the mont QA meeting. Date of Comp will be 7/3/11.	pe ext 3 after or or idit hly
	Council meeting 2:35 p.m., lacke	six months of Resident g minutes on 6/2/11 at ed indication that ents were reviewed.			
	at 9:59 a.m., wi Resident #28, t	n interview on 6/2/11 th Council President, he resident stated she of Resident Rights.			
	at 1:17 p.m., wi	n interview on 6/2/11 th Resident #29, the she was not aware of s.			
	at 2:13 p.m., wi	n interview on 6/2/11 th Resident #26, the she was not aware of s.			
	3.1-4(a) 3.1-4(f)(3)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/03/2011			
	PROVIDER OR SUPPLIER S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
F0167 SS=B	of the most recent conducted by Fed any plan of correct the facility. The facility must may be for examination and readily accessible a notice of their averaged by the facility and because the facility must may be for examination and readily accessible a notice of their averaged by the form of the facility of the fa	rvation, record review, the facility failed to the ware aware of the most recent Indiana ent of Health survey 4 sampled residents location of state of the 24 residents who in the Stage 2 review.	F0167	F 167 Resident's #28, 29, and 26 reeducated on where to look where the state survey resilocated during the Resident Council Meeting held on 6/ This deficient practice had potential to affect all reside the facility. The location of state survey results were reviewed with all resident's attendance of the Resident Council Meeting held on 6/ (Attachment #3). All other resident's not in attendance be re-educated by 7/3/11 of Resident Rights and quarte thereafter. The Social Sendirector will be responsible reviewing the location of th survey results and will be reflected in the Resident Co Meeting Minutes every mon The Social Service Quality Assessment will be comple	cate ults are t 9/11. the nt's in the in t 9/11 e will on erly vice e for e state ouncil onth.		

		IDENTIFICATION NUMBER:	A. BUII	LDING	NSTRUCTION 00	(X3) DATE SU COMPLE 06/03/20	TED
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X4) ID SUMMARY STATEME (EACH DEFICIENCY MUST REGULATORY OR LSC IDE 9:59 a.m., with CounResident #28, the resident #28, the resident state survey resident stated she delocation of most receives results.		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Council President, he resident stated she e location of most rvey results. Interview on 6/2/11 at in Resident #40, the she did not know the t recent state survey Interview on 6/2/11 at Resident #26, the she did not know the	Ì	LDING G STREET A 11563 V		comple 06/03/20 The the ven tion ol e ext 3 after or or	TED
	a.m. the most r	tion on 6/2/11 at 9:59 ecent state survey a labeled binder, on a trance hallway.			QA meeting. Date of Compli will be 7/3/11.	ance	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		(X2) MULT A. BUILDIN B. WING		00	(X3) DATE: COMPL 06/03/2	ETED	
MILLER'	PROVIDER OR SUPPLIER		1	1563 W DUNKIR	DDRESS, CITY, STATE, ZIP CODE EST 300 SOUTH K, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0168 SS=B	from agencies actibe afforded the opagencies. Based on interviting the facility failed were aware of the facility failed who was a supplied to the facility failed with a supplied with a sup	right to receive information ing as client advocates, and portunity to contact these view and record review, do to ensure residents the ombudsman for 4 esidents interviewed for ecombudsman was, stact him/her, of the 24 were included in the contact where included in the contact where the did not know who has, or how to contact the did not know who has, or how to contact where included in the contact where included in the she did not know who has, or how to contact interview on 6/2/11 at a Resident #40, the he did not know who has, or how to contact interview on 6/2/11 at Resident #29, the he who ombudsman	F016	8	F 168 Resident's #28, 40, 29, and 2 were reeducated on where to locate the contact informatio the local Ombudsman and w the Ombudsman is during the Resident Council Meeting he 6/9/11. This deficient practic had the potential to affect all resident's in the facility. The contact information for the located of the contact information for the located on 6/9/11 (Attachment All other residents in attendant the Resident Council Meeting held on 6/9/11 (Attachment All other residents not in attendance will be re-educated 7/3/11 on Resident Rights are quarterly thereafter. The Socated Director will be responsible for reviewing the contact information for the located of the Resident Council Meeting Minutes every mont. The Social Service Quarterly Assessment will be completed the Social Service Director of designee quarterly on all residents and will include documentation of contact information for the local Ombudsman and who the Ombudsman is. Also a post	on for ho for ho for ho e eld on se ed ce of g #3). ed by ho dial ed cial ed	07/03/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 06/03/2011	
	PROVIDER OR SUPPLIER		1156	ET ADDRESS, CITY, STATE, ZIP CODE 33 WEST 300 SOUTH JKIRK, IN47336	00/03/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	was, or how to 4.) During an in 2:13 p.m. with I resident stated ombudsman was her. The Resident C minutes, dated the most recent reviewed on 6/2 lacked any info Ombudsman at	contact her. Interview on 6/2/11 at Resident #26,the she did not know who as, or how to contact Council meeting from 8/8/10 through ton May 13, 2011, 2/11 at 2:35 p.m., rmation related to the stending any council facility providing		will be placed on the Activity Calendar, which is given to a resident and posted within the facility, of where residents callocate the contact information the local Ombudsman and withe Ombudsman is. Correct action will be monitored utilize the QA Tool "Resident Right Review" (Attachment # 4). It will be completed monthly for next 3 months then quarterly thereafter by the Social Service Director or designee. Result the audit will be reviewed in monthly QA meeting. Date of Compliance will be 7/3/11.	each ne an n for tho tive zing This r the tice ts of the
F0226 SS=D	written policies and mistreatment, negrand misappropriat Based on record the facility failed member of the aware of and writing policy in prevention of all potential resider front line supersistence.	nd reporting of nt abuse for 1 of 3 visors reviewed for on, reporting, and	F0226	F 226 It is the policy of Mille Merry Manor, Dunkirk to devand implement written policicand procedures that prohibit mistreatment, neglect, and a of residents and misapproprof resident property. All resihave the potential to be affer by this deficient practice. Somember LPN #4 indicated in interview has been re-education the facility abuse policy.	relop es abuse fation dents cted taff the the

[i ′		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155571	B. WIN	IG		06/03/2	011
NAME OF I	PROVIDER OR SUPPLIEF	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•		11563 V	VEST 300 SOUTH		
MILLER'	S MERRY MANOR			DUNKIF	RK, IN47336		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	-		DATE
TAG	Findings included 1.) Review of the policy, dated 8. Prohibition, Relativestigation, Director of Nursalm, included the following: "1. Policy: It is the policy of Systems that a right to be free physical and many punishment, and seclusion Miller's Health and procedures that all alleged mistreatment, relativestigation including injuried and misapproperty are resulted that the procedures of the following in the procedures (including in the procedures)	the current facility /23/10, titled "Abuse porting, And provided by the sing on 6/2/11 at 10:45 but was not limited to, of Miller's Health Il residents have the from verbal, sexual, tental abuse, corporal		TAG	6/29/11 regarding the identification of abuse and procedures for intervention a reporting. Silver Chair inservans been added for the month June regarding abuse and wompleted by 7/3/11 by all st. This will be monitored by the process utilizing QA Tool "Ab (Attachment # 5). This will be completed monthly indefinite the Administrator or designed This QA Tool will be discussed and reviewed in the QA meemonthly. Any issues identified be addressed immediately. Date of Compliance will be 7/3/11.	roper and vice th of ill be aff. QA use" e ly by e. ed ting ed will	DATE
		Systems has policies					
	Lang procedure	s in place that all					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/03/2	LETED
	PROVIDER OR SUPPLIER S MERRY MANOR		B. WIN	11563 V	ADDRESS, CITY, STATE, ZIP CODE WEST 300 SOUTH RK, IN47336	00/00/2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	investigated, ar	ns are thoroughly nd must prevent further while the investigation ."					
	policy, dated 4/ Director of Nurs a.m., titled "Res	the current facility 26/11, provided by the sing on 6/2/11 at 10:45 sident Abuse" included, ited to, the following:					
	"5. Resident						
	B. Procedure 1. If resident al abuse, is report	buse, or suspicion of					
		t(s) involved in the removed from the e.					
	incident shall in Charge Nurse of which the resid Charge Nurse of resident(s) invo	al who witnessed the namediately notify the of the Nursing Unit ent occupies The will examine the olved to determine if a have occurred, and					
	_	Nurse is responsible ility Administrator and sing Services					

	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO.	00	COMPL	
		155571	B. WIN			06/03/2	011
	PROVIDER OR SUPPLIER			11563 V	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	alleged abuse the facility at or suspended unt completed. At will be initiated conduct policie appropriate" 3.) During an in 11:00 a.m., the scenario was pure in the	and she was telling being combative with he CNAs did not want the other CNA stated ahead and get the cause they needed to done. The resident ruggle with the CNAs but the CNAs got her up into a chair. as very upset. er was completed. did not want to proceed or, came to the nursing orted the incident to					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 06/03/2	ETED
	PROVIDER OR SUPPLIER S MERRY MANOR	!		STREET A	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	fictional scenarion be required to the incident to indicated the binave been for resident alone return later. When queried to do based on to her by the Condition would talk to the getting the resire port her to (not Nursing) if the when informed upset and asked CNA continue indicated she will be she will be she indicated she wi	ueried about the rio and what she would do if the CNA reported her. The LPN est approach would the CNAs to leave the for a little while and what she would need the information given NA, she indicated she re CNA who insisted on dent up and would ame of Director of problem continued. If the resident was very red if she would let the to provide care, she would "probably not." she might have her go om while she contacted for of Nursing) for no time during the resident for any signs stress or physical					

PROVIDER'S PLAN OF CORRECTION	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	SURVEY LETED
MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and training provided to LPN#4. Review of an inservice record for LPN 11563 WEST 300 SOUTH DUNKIRK, IN47336 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) AND PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) AND PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)		.011
MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and training provided to LPN#4. Review of an inservice record for LPN DUNKIRK, IN47336 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	AME OF PROVIDER OR SUPPLIE	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) And training provided to LPN#4. Review of an inservice record for LPN PREFIX TAG PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) DATE		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE And training provided to LPN#4. Review of an inservice record for LPN		(X5)
and training provided to LPN#4. Review of an inservice record for LPN	, ,	COMPLETION
Review of an inservice record for LPN		DATE
Nursing on 6/2/11 at 4:15 p.m, indicated LPN #4 had completed an "Resident's Rights" and "Preventing, Recognizing, and Reporting Resident Abuse" inservice on 4/2/11. 3.1-28(a) A resident has the right to receive notice before the resident's room or roommate in the facility is changed.	and training p Review of an #4, provided to Nursing on 6/2 indicated LPN "Resident's R Recognizing, Abuse" inserved 3.1-28(a) A resident has the before the reside facility is changed Based on record the facility fail was notified on 1 sampled resonotification of residents who stage 2 review Findings inclusion 1.) During ar 3:09 p.m., with resident state after 4 weeks 2.) A facility titled "Room Transfer," pro 6/3/11 at 9:45	07/03/2011

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED
	PROVIDER OR SUPPLIER		<u>'</u>	11563 V	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	B. PR	facility Transfer: OCEDURE: ify the resident,prior			(Attachment #4) monthly for next 3 months and quarterly thereafter by the Social Serv Director or designee. This w reviewed in the monthly QA team. Date of Compliance v 7/3/11.	ice ill be	
	,	al record for Resident ed on 6/3/11 at 8:46					
	assessment (M indicated Resid Interview for M score of 14, wh	Minimum Data Set IDS), dated 5/22/11, dent #7 had a Brief ental Status (BIMS) nich indicated the ognitively intact.					
	A physician's o was dated 5/19	rder for room change 9/11.					
	dated 5/19/11, Power of Attorn finances, and v appointed heal and payee, was change by pho						
	8:56 a.m., the	interview on 6/3/11 at Administrator indicated ge was discussed with					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/03/2011
	PROVIDER OR SUPPLIER		STREET A 11563 V	ADDRESS, CITY, STATE, ZIP CODE WEST 300 SOUTH RK, IN47336	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	family wanted a soon as one was 5.) During an 9:28 a.m., the S Director indicat was discussed admission, but	interview on 6/3/11 at Social Services ed the room change			
F0248 SS=D	program of activitic accordance with the assessment, the inmental, and psychological resident. Based on obserview, and integrated to ensure met resident actions three residents.	rvations, record erviews, the facility the activity program ctivity needs for one of in a sample of seven met the criteria for	F0248	F 248 It is the policy of Mille Merry Manor, Dunkirk to pro an ongoing program of activ designed to meet, in accorda with the comprehensive assessment, the interests ar physical, mental, and psychosocial well-being of e resident. Resident # 21 has been offered activities outsice	vide ities ance nd the ach

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155571	B. WIN			06/03/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				WEST 300 SOUTH		
MILLEDIS	S MERRY MANOR			1	RK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
	Findings includ	e:			accordance with her Plan of	4.0	
					Care. On 6/9, 6/13, 6/14, 6/	16,	
	Observations o	f Resident #21			6/17, and 6/21 Resident #21	٥.	
	included:				actively participated in outdo activities (Attachment # 9).		
					Activities (Attachment # 9). Activity Director will be	ille	
	5/31/11 at 2:15	P.M. and 3:10 P.M.:			responsible to document on	a l	
					daily basis these activities al		
		as sitting in her room in			with all other activities provid	-	
	her recliner cha	•			and/or refused. This deficier	nt	
	material was ob	oservea.			practice had the potential to		
					all other resident's in the faci	-	
	6/1/11 at 9:20	A.M.: The resident			All activity Care Plans will be		
	was sitting in he	er room in her chair			reviewed by 7/3/11 to ensure		
	with no activity	involved.			accuracy of residents needs concerns, and measurable g		
	ĺ				are being met. Appropriate	Uais	
	 6/1/11 at 1:45 F	PM, 3:05 P.M., and			interventions will be impleme	ented	
		resident was sitting in			and made certain to be in pla		
		•			and followed by the		
		chair. No reading			interdisciplinary team. All Ca	are	
	material was of	oservea.			Plan's are reviewed on a qua	-	
					basis and with any significan		
	The weather οι	utside the facility on			change to a resident's condit		
	6/1/2011 was s	unny and warm all day			A QA Tool "Care Plan Review		
	with temperatur	res ranging from the			(Attachment #6) will be comp		
	•	s through the mid 80			by the Administrator or desig This will be completed month		
	_	/31/2011 and 6/1/2011,			3 months then quarterly	ily ioi	
		ents were observed			thereafter. Corrective action	will	
	•				be monitored in the monthly		
		ay in rocking chairs on			meeting and any issues will		
	' '	neelchairs on the			addressed. Date of Complia	nce	
	porcn, or walkir	ng on facility grounds.			will be 7/3/11.		
	Review of the o	clinical record for					
	Resident #21 o	n 6/1/11 at 2:00 P.M.,					
	included the fol	lowing Activity Care					
		1/11, which included,					
	but was not lim						
	Dat was not min						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155571	A. BUILDING	00	COMPLETED 06/03/2011
		100071	B. WING		00/03/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MILLER'S	S MERRY MANOR			WEST 300 SOUTH RK, IN47336	
				1 1111, 11147 550	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Focus: Feeling	is of sadness			
	_	iety, uneasiness,			
	depression cha	9			
	•	ng, low self esteem,			
	tearfulness, mo	•			
		n care/activities related			
	to: relocation. I	Prefers to stay in room			
		group activities.			
	Resident is har	d of hearing, reads			
	some lips, and	enjoys reading.			
	Daughter visits	as often as can.			
	Goals: Resider	nt will have no s/s			
	(signs and sym	ptoms) of mood			
	decline. To sho	ow physical sign stress			
	is being alleviat	-			
		ther than self. Accept			
		cation as prescribed.			
		olved with self initiated			
		oice. Will encourage			
	two group activ	•			
	Supervised out				
	weather permit	S.			
	Intomiontions	Disquas facilises shout			
		Discuss feelings about			
	•	resident. Discuss er and options of			
		anneling of these			
		sident. Encourage			
	_	eep in contact/visit as			
	much as possib	•			
	•	ress feeling. Give			
		per physician orders.			
	-	status/mood state			
	changes as nee				
	Changes as nee	eueu. FIOVIUE			

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR IDDINITION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Emotional support to resident and or family as needed. Assist with outdoor events as weather and health permits. Offer groups and encourage participation for increased socialization. Offer in room activities. Praise all efforts. Provide assistance as needed. Provide independent in room activities as requested. The current care plan for activities, dated 5/31/2011, included: Focus: Feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Emotional support to resident and or family as needed. Assist with outdoor events as weather and health permits. Offer groups and encourage participation for increased socialization. Offer in room activities. Praise all efforts. Provide assistance as needed. Provide independent in room activities as requested. The current care plan for activities, dated 5/31/2011, included: Focus: Feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by
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Focus: Feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by
emptiness, anxiety, uneasiness, depression characterized by
emptiness, anxiety, uneasiness, depression characterized by
depression characterized by
in affective continue lavorable actions
ineffective coping, low self esteem,
tearfulness, motor agitation,
withdrawal from care/activities related
to: relocation.
Prefers to stay in room and not attend
group activities. Resident is hard of
hearing, reads some lips, and enjoys
reading. Daughter visits as often as
can.
Cooley Besident will have no a/a
Goals: Resident will have no s/s
(signs and symptoms) of mood
decline. To show physical sign stress
is being alleviated. Carry on
conversation other than self. Accept
care and medication as prescribed.
Resident will be satisfied with self
initiated activities, will encourage two
group activities monthly of choice,

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPL	
		155571	B. WIN			06/03/2	011
NAME OF I	PROVIDER OR SUPPLIER	" {	'	1	ADDRESS, CITY, STATE, ZIP CODE		
MULED				1	VEST 300 SOUTH		
	S MERRY MANOR				RK, IN47336		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	one to one visi	ts one time weekly, and					
		door wheelchair					
	rides/other out	door events as weather					
	permits.						
	Intonionai	Discuss facilings shout					
		Discuss feelings about resident. Discuss					
	l ·	er and options of					
		anneling of these					
	feelings with re	sident. Encourage					
	loved ones to k	keep in contact/visit as					
		ole. Encourage					
		ress feeling. Give					
		per physician orders.					
		status/mood state					
	changes as ne	oort to resident and or					
		ed. Assist with outdoor					
		ther and health permits.					
	Offer groups a						
	participation fo	r increased					
	socialization. (Offer in room activities.					
		s. Provide assistance					
		ovide independent in					
	room activities	as requested.					
	Review of the	Activity Attendance					
		11 through the present					
	_	Director on 6/2/11 at					
		icated the resident had					
	not been in an	outside activity during					
		me. The resident's					
	1	ince logs for this period					
		esident only attended					
	group activities	once or twice a					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/03/2	ETED
		100071	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	011
NAME OF I	PROVIDER OR SUPPLIEF				VEST 300 SOUTH		
	S MERRY MANOR				RK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1710	month, and he	*		ing	<u> </u>		DATE
		l activities included					
		the beauty shop and					
	· ·	eshments served in her					
	room.						
	Review of a qu	arterly activity					
		ated 3/7/11, included,					
	but was not lim	ited to: "has little					
		p activities, prefers to					
	'	Has breakfast in dining					
		portive family, visits					
		s been going through					
		dical treatments lately.					
		cult to read. Added					
	I -	door events as weather					
	permits to her	Sare plan.					
	The resident's	activity care plans had					
		neasurable goals and					
		address the resident's					
	activity prefere	nces and needs. The					
		no additional updated					
		reflect the resident's					
	preference to r	emain in her room in					
	the afternoons,	her refusal to attend					
	offsite activities	s, and her recent					
	decline in abilit	y to read books and					
	magazines.						
		th Resident # 21 on					
		P.M., indicated she is					
		and cannot attend					
		r own." She indicated					
	she was not av	vare of any activities					

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OF OF THE CONTROL OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	A. BUILDING	CONSTRUCTION 00	li i	E SURVEY PLETED 2011
PROVIDER OR SUPPLIER S MERRY MANOR		1156	ET ADDRESS, CITY, STATE, ZIP CO 3 WEST 300 SOUTH KIRK, IN47336		
S MERRY MANOR SUMMARY S (EACH DEFICIEN REGULATORY OR available in the weekends, but anyway as she chair. She indi books to read." A follow up inte #21 on 6/2/11 a she would like to often if the wea also indicated s plants. An interview wi on 6/2/11 at 1:5 tries to have ar month if possib Resident #21 re consistently, bu said she would more. She indi this resident ou	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) evening or on could not attend them cannot get out of her cated "they bring me	1156		RECTION IOULD BE	(X5) COMPLETION DATE
her wheelchair she thought the been outside or summer. The A documentation	in the morning, and resident had only ne time this spring and Activity Director had no the resident had been ctivity or outside on the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155571 06/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11563 WEST 300 SOUTH MILLER'S MERRY MANOR DUNKIRK, IN47336 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must provide housekeeping and F0253 maintenance services necessary to maintain SS=E a sanitary, orderly, and comfortable interior. F 253 It is the policy of Miller's F0253 07/03/2011 Based on observation and interview, Merry Manor, Dunkirk to provide the facility failed to ensure, wooden housekeeping and maintenance entrance doors to resident rooms services necessary to maintain a were properly maintained for 16 of 24 sanitary, orderly, and comfortable wooden doors observed (rooms 100, interior. All resident's have the potential to be affected by this 101,102, 104, 107, 108, 110, 111, deficient practice. All resident 112, 114, 202, 203, 206, 207, 210, entrance doors and resident and 214); failed to ensure metal door bathroom doors will be filled. frames leading to resident bathrooms sanded, and made smooth. They were in good repair for 6 of 24 metal will all be completed on 6/24/11. The resident shower room in the door frames observed (rooms 110, facility has had tiles replaced on 111, 112, 115, 118, and 201) and the walls and floor, and any rough failed to ensure the resident shower edges have had covers placed room was properly maintained for 1 of over them and are smooth 1 shower room observed. surfaces. The other shower room that was previously not in working order will be completely refinished Findings include: and completed on 7/1/11. The Maintenance Director will monitor During the environmental tour with the the resident doors and door frames as well as the shower Maintenance Director and the room in a Preventative Administrator on 6/2/11 at 1:30 p.m.. Maintenance QA (Attachment # 7) the following concerns were identified, to be completed monthly. Inspection is to be completed in A. The wooden entrance doors to resident bathing areas and any issues identified will be resident rooms were rough, gouged. addressed immediately. Will marred, and had bare wood exposed review any findings in the monthly on doors to room numbers, 100, 101, QA meeting and will address any 102, 104, 107, 108, 110, 111, 112, issues. Date of Compliance will 114, 202, 203, 206, 207, 210, and be 7/3/11. 214. B. The metal door frames to the

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	te survey ipleted 8/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	entrance of restrough, gouged on the bathroom numbers, 110, 201. C. The only retthe facility had concern, a.). Twenty (20 were missing. approximately approximately areas where the b.) Ten (10) see were gouged, see discolored. The approximately size. c.) The shower sections where The paint was attached to the approximately actions where the approximately actions where the paint was attached to the approximately actions.	ident bathrooms were, and had paint peeling in doors in room 111, 112, 115, 118, and sident shower room in the following areas of a sections of wall tiles. The wall tiles were in the wall tiles were in the etiles were missing. In the wall tiles were in the etiles were missing. In the wall tiles were in the etiles were missing. In the wall tiles were in the etiles wall in 2 sections in the etiles in size. In the was in place to the tape was in place to the tape was in place to imately 2 feet in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/03/2011				
	NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	2:30 p.m., he ir of all of the abo environmental	concerns. He further d not had time to						

l	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 06/03/2011			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336					
	S MERRY MANOR SUMMARY S (EACH DEFICIEN		11563 V	WEST 300 SOUTH		(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155571	B. WING	1110		06/03/2	011
			l	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/EST 300 SOUTH		
	S MERRY MANOR			DUNKIR	RK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	A facility must use	the results of the velop, review and revise the					
SS=E		nensive plan of care.					
	resident's compret	ichaive plan of care.					
	The facility must develop a comprehensive						
		resident that includes					
		tives and timetables to meet					
	a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	comprehensive as	Sessificiti.					
	The care plan mus	st describe the services that					
		d to attain or maintain the					
		practicable physical,					
		osocial well-being as					
		83.25; and any services that e required under §483.25					
		ed due to the resident's					
	•	under §483.10, including the					
	right to refuse trea	tment under §483.10(b)(4).					
	Based on recor	d review, observation,	F02	79	F 279 It is the policy of Miller		07/03/2011
	and interview, t	he facility failed to			Merry Manor, Dunkirk to use	the	
	ensure a comp	rehensive health care			results of the assessment to develop, review, and revise t	ho	
	plan was devel	oped for 5 of 19			resident's comprehensive pla		
	residents reviev	•			care.	0.	
		health care plan			Resident #24: Care plan has	;	
	•	a Stage 2 sample of			been reviewed and updated		
	•	's 24, 41, 21, 50, and			include dental concern. Resi		
	30.)	· · · · · · · · · · · · · · · · · ·			will be seeing dentist on his r		
	55.,				visit in facility. Resident is had no adverse effects related to		
	Findings includ	0.			issue.		
	Findings includ	С.			Resident # 41: The resident		
	1 \ The elipical	record for Decident			record has been reviewed.		
	· •	record for Resident			Diagnosis of essential tremor		
		ed on 6/1/11 at 2:00			has been added. Pharmacy h		
	p.m.				reviewed the medication. The physician has provided	e	
					documentation for the use of	the	
	_	Resident #24 included,			medication and the care plan		
	but were not lin	nited to, senile			been reviewed and updated.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO		COMPLE	TED	
		155571	B. WIN			06/03/20	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1			
MILLED					VEST 300 SOUTH RK, IN47336		
WILLER	S MERRY MANOR			DOINKI	RK, 11147330		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	\bot	TAG	DEFICIENCY)		DATE
	dementia with	delusional features,			Resident # 21: The residents		
	depressive dis-	order, and anemia.			Care Plan has been reviewe	d and	
					updated.		
	During an interview on 5/31/11 at 3:30				Resident # 50: Has been discharged from the facility.		
	1 -	#24 indicated she had			Resident # 30: The resident	,	
	1 '	ling "a few days ago."			Care Plan has been reviewe		
	1				updated. The resident has b	· · · · I	
		the tooth didn't hurt and			placed on a behavior monito		
	sne planned to	see the dentist.			program.	-	
					All resident's have the poter		
	The nursing notes indicated the resident lost the filling from an upper tooth on the right side on 5/8/11. The				to be affected by this deficien		
					practice. All comprehensive		
					Plans will be reviewed by 7/3	3/11	
	notes indicated	the resident's son was			by the Director of Nursing or designee to ensure accuracy	, for	
	notified of the t	filling coming out and			problems identified, measura		
	1	resident to be seen			goals, and appropriate		
		t dentist visit to the			interventions. All Care Plans	are	
	1				reviewed on a quarterly basi	s and	
	facility unless s	•			with any significant change t		
	1	from the lost filling			resident's condition. A QA T		
	which he would	d address at that time.			"Care Plan Review" (Attachn		
					# 6) will be completed by the		
	Subsequent nu	ırsing note entries			Director of Nursing or design		
	indicated the s	taff was aware of the			This will be completed month 3 months then quarterly	ily ioi	
	lost filling and	monitored the resident			thereafter. Corrective action	will	
	for pain or prob	olems chewing through			be taken immediately and	••••	
	1 ' '	ast nursing note entry			reviewed in the monthly QA		
	1	al concerns was dated			meeting. Date of Compliance	e will	
	5/21/11 at 2:14				be 7/3/11.		
	J/2 1/ 11 at 2.14	· μ.π.					
	The elimination	and lasted and					
	1	cord lacked any					
	· •	e health care plan					
	_	eveloped related to					
	Resident #24 h	naving lost a dental					
	filling, the pote	ntial for pain or					
	sensitivity to he	ot and/or cold foods,					
	1	lications with chewing,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET A	NDDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	and the need to next visit to the	o see the dentist on his facility.					
	care plan (HCF Resident #24 v The conference information relation relations the need to mose the dentist. During an interior Nursing on 6 additional information related to the late comprehensive developed regallost filling, then any pain or derineed to see the facility visit. The facility failed additional information for 6/3/11. 2.) The clinical #41 was review p.m. Diagnoses for but were not linocclusion with	e HCP having been arding the resident's need to monitor for ntal concerns, and her e dentist during his next ed to provide any mation as of exit on record for Resident wed on 6/1/11 at 2:30 Resident #41 included, mited to, cerebral artery infarction, diabetes tial tremors, and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER		1	STREET A	NDDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
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	5/5/11, indicated received Primic (mgs) 1 tablets (100 mg 2012 Nursing I indicated this manti-seizure mercord lacked a seizure activity. During an interp.m., the Directindicated she horder for the Prand it was order tremors. She is had a problem leg. The clinical rectare planning in having problem tremors requirin Primidone medication and increased tremore. During an interpolation of Nursing (DC on 6/3/11 at 10 information was	ian's orders, signed and Resident #41 done 50 milligrams at 8 a.m. daily and 2 g) at 8 p.m. daily. The Drug Handbook hedication was an edication. The clinical any diagnosis of for Resident #41. In view on 6/2/11 at 3:40 for of Nursing (DON) had found the original rimidone medication ered for essential indicated Resident #41 with tremors of his left for the lication and/or the need for the lication and/or the need for the diany problems with ors. In view with the Director of the lication and don's the need for the lication and/or the need for the lication and/or the need for the diany problems with ors. In view with the Director of the lication and and and and and and and and and an					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155571	B. WIN			06/03/2	2011
	PROVIDER OR SUPPLIER			11563 V	ADDRESS, CITY, STATE, ZIP CODE WEST 300 SOUTH RK, IN47336	•	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	_	nosis of essential ng the need for the					
	_	ed to provide any mation as of exit on					
	,	50's clinical record was 2/11 at 12:56 p.m.					
	The resident's diagnoses included, but were not limited too, closed						
	fracture of shaf	·					
	hypertension; a thrombocytope						
		obesity; and urine					
	signed on 5/26/ a 5/11/11, Phys warfarin [an and [milligrams] dail after the warfar resident was to	ohysician's orders were 11. The resident had sician's order for ti-coagulant] 2 mg ly for ten days and in was completed the start on buffered					
	The resident ha	daily for four weeks. ad a 5/22/11, er for Klonopin 0.5 mg ours prn [as needed]					
		nd a 5/22/11, mum Data Set [MDS] dicated the resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155571	B. WIN			06/03/2	011
	PROVIDER OR SUPPLIER		•	11563 V	ADDRESS, CITY, STATE, ZIP CODE WEST 300 SOUTH RK, IN47336		
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TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	had no memory	problems.					
	A nurse progres at 10:04 a.m., in #50's physician Ditropan XL 10 retention and K 6 hours prn for requested. The she was on the admittance. A nurse progres at 4:34 a.m., in was waking up to urinate after clonazepam [get The resident has focus of: Poter psychotropic m characterized becardiac, neuron gastrointestinal by: hypotensio unsteady gait/b Activities of Dai interventions for 1. Administer mordered. 2. Evaluated ever effects of medical 3. Notify Medical control of the state o	as note, dated 5/20/11 Indicated Resident In was notified and Img, for urinary Ilonopin 0.5 mg, every Ilonopin 0.5					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			TED		
		155571	B. WIN			06/03/20	11	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			11563 V	WEST 300 SOUTH			
MILLER'S MERRY MANOR				DUNKI	RK, IN47336			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	<u> </u>	DATE	
		ad a 5/17/11, Care Plan						
	focus of: Resid							
		od problems related to						
	placement in a	n extended care facility						
		els it is safe for her to						
	return home. T	he interventions for						
	this problem we	ere:						
	Allow reside	ent to verbalize fears or						
	concerns.							
	2. Listen attent	tively and follow-up on						
	issues prn.							
	3. Provide support and							
	encouragemen	•						
		•						
	The resident ha	ad no care plan related						
		or risks or side effects						
	_	se of warfarin and had						
	no care plan re							
	· •	ogical interventions						
		of Klonopin being						
	administered.	or racriophi being						
	daniinisterea.							
	 During an inter	view with the Director						
		5/3/11 at 2:44 p.m., she						
	"	esident had been on						
		ne and had recently						
		•						
		cian so the medication rted at the resident's						
		ndicated the resident						
		n an anti-coagulant						
		g enough to develop a						
	care plan for it.							
	D. min at = 0/0/44	0.50 interview						
	1	, 2:50 p.m., interview						
	with MDS nurse	e, she indicated she						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER	!!	11563 V	ADDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
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	reviews and up when the MDS	dates the care plan is completed.				
	with LPN #5, sl are to update the medications are indicated Social notified if anti-a	, 2:52 p.m., interview ne indicated the nurses ne care plans when e changed. She al Services would be anxiety medications are I as a care plan				
	with LPN #6, sl to initiate care medications. S plan problem w	, 2:54 p.m., interview ne indicated nurses are plan problems for new She indicated a care yould be initiated for farin] related to				
	l '	30's clinical record was 1/11 at 2:25 p.m.				
	but were not lir diabetes melliti	diagnoses included, nited to, dementia; us; hypertension; eration of the retina.				
	signed and dat resident had a Xanax [an anti- mg tablet give	physician's orders were ed on 5/17/11. The 3/25/11, order for anxiety medication] 0.5 one half [0.25 mg] urs as needed for to dementia.				

l i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A.	BUILDIN	NG	00			
		155571	В.	WING				06/03/2	U11
NAME OF F	PROVIDER OR SUPPLIER			S	TREET A	DDRESS, CITY, STA	ΓE, ZIP CODE		
						/EST 300 SOUT	H		
MILLER'S	S MERRY MANOR				UNKIR	RK, IN47336			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		· II	D	PROVIDER'S PI	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL			EFIX	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Tz	AG	DEFI	CIENCY)		DATE
	The resident ha	ad a 4/3/11, admission							
	MDS assessme	ent. The assessment							
	indicated the re	esident had short term							
	memory proble	ms.							
	Review of the r	esident's Care Plan							
	indicated the re	esident had a 3/30/11,							
	Care Plan focus	s for							
	chronic/progres	ssive decline in							
	cognition chara	cterized by; deficit in							
	memory, judgm	nent, decision making							
	and thought pro	ocess related to							
	dementia. Inter	rventions for this							
	problem were:								
		ties into manageable							
	subtasks. Give	e one instruction at a							
	time to the resid								
		ess to clock/calendar.							
		explain procedures at							
		h interaction with							
	resident.								
		ad a 3/25/11, Care Plan							
		a hard time adjusting							
	•	supportive family,							
		tand why she is here.							
		g, wheelchair assist,							
		sses her pets. Enjoys							
		resh air when weather							
	is nice. Interve								
	Encourage a	•							
	participation and attendance.								
		urage and assist to							
	activities as nee	eded.							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID	DXG	R11	Facility II	D: 000519	If continuation sl	eet Pa	ge 37 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155571	B. WIN			06/03/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	-		11563 V	VEST 300 SOUTH	
	S MERRY MANOR			DUNKI	RK, IN47336	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		<u> </u>	+	TAG	DEFICIENC!)	DATE
	_	family and friends				
	visits.					
		rch services and				
	devotionals.					
	•	visits from volunteers				
	and family.					
		loor supervised events				
	as weather is w	arming an permits.				
	A 3/30/11, focus	s was for the resident				
	to adjust to sur	roundings, people, and				
	facility, and nev	v admission.				
	Interventions w	ere:				
	1. Activities to	remind resident and				
	encourage atte	ndance in activities.				
	2. Allow reside	ent to verbalize fears or				
	concerns relate	ed to health condition				
	or extended ca	re facility placement.				
		resident to let staff				
	_	likes to eat and how				
	she likes care,					
		cility, room and unit				
	schedules, intro	-				
	•	admission and prn.				
	•	rmation regarding				
	schedule, routii	•				
	information faci					
	6. Provide sup					
	encouragemen	•				
	Choodiagomen	· piii.				
	The clinical rec	ord lacked a focus or				
	interventions fo					
		to administering				
	Xanax.	to daminiotoring				
	Adrian.					

000519

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2011		
	PROVIDER OR SUPPLIER	<u> </u>		11563 W	DDRESS, CITY, STATE, ZIP CODE /EST 300 SOUTH RK, IN47336		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
	REGULATORY OR A 4/6/11, 3:54 a indicated the rewandering arous shift. She is ward aughter to go attempts at redunsuccessful. A 4/11/11 4:00 indicated the rest the hall wearing for the bathroo another resider incontinent of the contract of the uncontract of the uncontract of the contract of the uncontract of the uncontract of the contract of the uncontract of the contract of the contract of the uncontract of the contract of t	a.m., progress note esident was call her home. Several lirection were esident was wandering g just a towel looking m. She had been in a she floor. 8 a.m., progress note esident has been up and several times this enting to call her home. Several lirection were a.m., progress note esident was wandering g just a towel looking m. She had been in ant's room and was he floor. 8 a.m., progress note se of two staff to check resident is telling her and and the family is	Pl		(EACH CORRECTIVE ACTION SHOULD	BE	
	indicated confu The resident the During an inter p.m., the Social indicated the red documented or Administration the resident was	p.m., progress note used with time of day. cought it was breakfast. view on 6/1/11 at 2:20 al Service Director esident's behavior were in the Medication Record. She indicated as not on a behavior indicated the resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155571	B. WIN			06/03/2	011
	PROVIDER OR SUPPLIER			11563 V	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	an emergency increased deme						
	with the Director indicated the reprior to admissi daughter was go Xanax 0.5 mg light The Director of resident's daughter frequence in the process of the resident being in the resident being included: 5/31/11 at 2:15 The resident was observed in the recliner characterial was observed in the receive in the receive in the resident was observed in the receive in the	P.M. and 3:10 P.M.: as sitting in her room in hir. No reading oserved. A.M.: The resident er room in her chair involvement. P.M., 3:05 P.M., and eresident was sitting in rehair. No reading oserved.					
	The weather ou	utside the facility on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 06/03/2011			ETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	VEST 300 SOUTH		
	S MERRY MANOR			1	RK, IN47336		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
1710		sunny and warm all day		ing	<u> </u>		DATE
		res ranging from the					
	mid 70 degrees through the mid 80						
	1	5/31/2011 and 6/1/2011,					
	•	ents were observed					
	I .	ay in rocking chairs on					
		heelchairs on the					
	porch, or walki	ng on facility grounds.					
		clinical record for					
		on 6/1/11 at 2:00 P.M.,					
		llowing Activity Care					
	1 '	31/11, which included,					
	but was not lim	nited to:					
	 Focus: Feeling	ns of sadness					
		kiety, uneasiness,					
	depression cha	•					
	1 '	ing, low self esteem,					
	tearfulness, mo	_					
		n care/activities related					
	to: relocation.						
	1	in room and not attend					
	group activities	s. Resident is hard of					
	1	some lips, and enjoys					
	reading. Daug	hter visits as often as					
	can.						
	Goals: Reside	nt will have no s/s					
		nptoms) of mood					
	, ,	ow physical sign stress					
	is being allevia						
	_	ther than self. Accept					
		cation as prescribed.					
		olved with self initiated					

II I	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O	COMPLETED
155571 A. BUILDING B. WING	06/03/2011
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 11563 WEST 300 SOUTH	
MILLER'S MERRY MANOR DUNKIRK, IN47336	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
activities of choice. Will encourage	
two group activities monthly.	
Supervised outdoor events as	
weather permits.	
Interventions: Discuss feelings about	
placement with resident. Discuss	
'	
feelings of anger and options of	
appropriate channeling of these	
feelings with resident. Encourage	
loved ones to keep in contact/visit as	
much as possible. Encourage	
resident to express feeling. Give	
medication as per physician orders.	
Monitor mental status/mood state	
changes as needed. Provide	
emotional support to resident and or	
family as needed. Assist with outdoor	
events as weather and health permits.	
Offer groups and encourage	
participation for increased	
socialization. Offer in room activities.	
Praise all efforts. Provide assistance	
as needed. Provide independent in	
room activities as requested.	
The current care plan for activities,	
dated 5/31/2011, included:	
Focus: Feelings of sadness	
Focus: Feelings of sadness,	
emptiness, anxiety, uneasiness,	
depression characterized by	
ineffective coping, low self esteem,	
tearfulness, motor agitation,	
withdrawal from care/activities related	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2011	
	PROVIDER OR SUPPLIER	<u> </u>	B. WIN	STREET A 11563 V	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
	group activities hearing, reads	in room and not attend c. Resident is hard of some lips, and enjoys hter visits as often as					
	(signs and symdecline. To she is being allevial conversation of care and medical Resident will be initiated activiting group activities one to one visit supervised out	nt will have no s/s nptoms) of mood ow physical sign stress ted. Carry on ther than self. Accept cation as prescribed. e satisfied with self es, will encourage two s monthly of choice, ts one time weekly, and door wheelchair door events as weather					
	placement with feelings of ang appropriate chapelings with reloved ones to be much as possil resident to expendication as Monitor mental changes as ne emotional supplication as need	Discuss feelings about resident. Discuss er and options of anneling of these sident. Encourage seep in contact/visit as ole. Encourage ress feeling. Give per physician orders. I status/mood state eded. Provide port to resident and or ed. Assist with outdoor ther and health permits.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' A. BUILDING B. WING (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' COMPLETE 06/03/2011			ETED			
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336					
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
TAG	Offer groups are participation for socialization. Or Praise all effort as needed. Proom activities Review of the ALogs from 3/1/with the Activity 2:00 P.M., independent in an another than this period of the activity attendation indicated the regroup activities month, and her room/individual weekly visits to occasional refer room. Review of a quassessment, distribution was not liminaterest in group stay in room. Has supervised out permits to her experience of the social permits to her experience and participation.	or increased Offer in room activities. Is. Provide assistance ovide independent in as requested. Activity Attendance 11 through the present or Director on 6/2/11 at icated the resident had outside activity during me. The resident's ince logs for this period esident only attended once or twice a or weekly in I activities included of the beauty shop and eshments served in her arterly activity ated 3/7/11, included, inted to: "has little p activities, prefers to has breakfast in dining oportive family, visits as been going through dical treatments lately. cult to read. Added door events as weather care plan."		TAG	DEFICIENCY)		DATE	
	The resident's	activity care plans had						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2011			
	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	no additional minterventions to activity prefere care plan had interventions to preference to me the afternoons offsite activities decline in ability magazines. An interview w 5/31/11 at 2:45 "is chair bound activities on he she was not available in the weekends, but anyway as she chair. She indibooks to read." A follow up interview w 5/31/11 at 2:45 "is chair bound activities on he she was not available in the weekends, but anyway as she chair. She indibooks to read." A follow up interview w 5/31/11 at 2:45 would like	neasurable goals and address the resident's nees and needs. The no additional updated oreflect the resident's emain in her room in her refusal to attend a, and her recent y to read books and ith Resident # 21 on P,M,, indicated she is and cannot attend ar own." She indicated ware of any activities evening or on could not attend them cannot get out of her icated "they bring me		TAG	DEFICIENCY		DATE	
	plants.	she liked to work with						
	on 6/2/11 at 1:5 tries to have ar month if possib Resident #21 r	ith the Activity Director 50 P.M., indicated she n offsite activity twice a ble. She indicated efuses these trips ut the resident had						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER			11563 W	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	said she would more. She indiction this resident outransferred back her wheelchair she thought the been outside of summer. The Adocumentation in an outside accompresent. The Amore information measurable go 6.) Review of the DoN on 6/3 included, but whe following: "To assure the care plan for easurable obto meet the resinursing, mentaneeds that are comprehensive process The comprehensive process The comprehensive process	like to go outside cated they had to take atside before she was at to her recliner from in the morning, and a resident had only ne time this spring and activity Director had no the resident had been civity or outside on the fall through the activity Director had no on to provide related to als for Resident #21. The current facility 1/2/10, titled "Care Plan a Review," provided by 1/11, at 9:56 a.m., as not limited to, the at a comprehensive ach resident includes jectives and timetables ident's medical, I and psychosocial identified in the					DATE

000519

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 00 CO.				TE SURVEY MPLETED	
		155571	B. WIN	G		06/03/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEST 300 SOUTH		
MILLER'S	S MERRY MANOR			DUNKIF	RK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
IAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	-	IAG	DEFICIENCE!)		DATE
		eatment goals and easurable outcomes					
	plan is develop admission to ac	interdisciplinary care ed within 24 hours of ddress pertinent issues nmediate concerns					
		resident i.e Fall risk,					
	pain, skin risk,						
	behavioral issu	es					
	PRN as change condition dictat but are not limit Physician order therapy change	ill be revised daily and es in the resident's e. Changes include ted to changes in rs, diet changes, es, behavior changes, ekin changes, etc"					
	policy, dated 5/ "Psychotropic I provided by the	Orug Use Policy," DoN on 6/2/11, at luded, but was not					
	drugs should or Evidence exits reasons for the been ruled out	that other possible residents distress has and use results in a approvement in the					

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTIPLE CC A. BUILDING B. WING	00	i .	E SURVEY PLETED 2011		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
IAU	evidenced in theE. BEHAVIC 1. When us anxiolytic, seda behaviors will be objectively more behaviors to be which cause the a danger to sel resident distress functional capa	ine medical record IR MONITORING: Sing an antipsychotic, ative or hypnotic, the quantitatively and initored daily. Specific the monitored are those the resident to represent the for others or cause the the sand impairment in the initial city. (see behavior and management	IAU			DATE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155571	B. WING			06/03/2	011
			P. 171111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				VEST 300 SOUTH		
MILLER'S	S MERRY MANOR		DUNKIRK, IN47336				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0280		he right, unless adjudged					
SS=D		nerwise found to be					
	incapacitated under the laws of the State, to participate in planning care and treatment or						
	changes in care and treatment. A comprehensive care plan must be						
		days after the completion					
		sive assessment; prepared					
		nary team, that includes the					
	• • •	n, a registered nurse with					
		ne resident, and other ndisciplines as determined					
		eeds, and, to the extent					
	•	urticipation of the resident,					
		ly or the resident's legal					
		d periodically reviewed and					
		of qualified persons after					
	each assessment.						
		rvations, record	F02	280	F 280 It is the policy of Mille		07/03/2011
	review, and inte	erviews, the facility			Merry Manor, Dunkirk that th resident has the right, unless		
	failed to revise	the activity care plan to			adjudged incompetent or	'	
	meet resident a	activity needs for one of			otherwise found to be		
	three residents	in a sample of seven			incapacitated under the laws	of	
	residents who r	met the criteria for			the State, to participate in		
	activities. (Res	sident #21).			planning care and treatment		
	,	•			changes in care and treatme Resident # 21 has been offer		
	Findings includ	e:			activities outside in accordan		
	. 5				with her Plan of Care. On 6/		
	Observations o	f Resident #21			6/13, 6/14, 6/16, 6/17, and 6/		
	included:				Resident #21 actively particip	oated	
	moluucu.				in outdoor activities (Attachm		
	E/24/44 at 0:45	D.M. and 2:10 D.M.:			9). The Activity Director will		
		P.M. and 3:10 P.M.:			responsible to document on a		
		as sitting in her room in			daily basis these activities al- with all other activities provid		
	her recliner chair. No reading				and/or refused. This deficier		
	material was ob	oserved.			practice had the potential to	-	
					all other residents in the facil		
	6/1/11 at 9:20	A.M.: The resident	<u></u>		All activity Care Plans will be		

j		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155571	B. WIN	G		06/03/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	VEST 300 SOUTH	
MILLER'S	S MERRY MANOR			DUNKIF	RK, IN47336	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		er room in her chair			reviewed by 7/3/11 to ensure	I
	with no activity	involved.			accuracy of residents needs, concerns, and measurable g	I
					are being met. Appropriate	odio
		P.M., 3:05 P.M., and			interventions will be impleme	ented
	3:55 P.M.: The	e resident was sitting in			and made certain to be in pla	ace
	her room in her	chair. No reading			and followed by the	
	material was ob	oserved.			interdisciplinary team. All Ca Plans are reviewed on a qua	
					basis and with any significan	
	The weather oเ	utside the facility on			change to a resident's condit	I
	6/1/2011 was s	unny and warm all day			A QA Tool "Care Plan Reviev	ν"
	with temperatur	res ranging from the			(Attachment #6) will be comp	
	mid 70 degrees through the mid 80				by the Administrator or desig	
	degrees. On 5	/31/2011 and 6/1/2011,			This will be completed month 3 months then quarterly	ily ioi
	up to five reside	ents were observed			thereafter. Corrective action	will
	outside each da	ay in rocking chairs on			be monitored in the monthly	QA
	the porch, in wh	neelchairs on the			meeting and any issues will be	
		ng on facility grounds.			addressed. Date of Complia	nce
	,	7 7 7			will be 7/3/11.	
	Review of the o	clinical record for				
	Resident #21 o	n 6/1/11 at 2:00 P.M.,				
	included the fol	lowing Activity Care				
		1/11, included, but was				
	not limited to:	, , , , , , , , , , , , , , , , , , , ,				
	Focus: Feeling	s of sadness,				
	emptiness, anx	iety, uneasiness,				
	depression cha	racterized by				
		ng, low self esteem,				
	tearfulness, mo	•				
		n care/activities related				
	to: relocation.					
		in room and not attend				
		. Resident is hard of				
	•	some lips, and enjoys				
	•	hter visits as often as				
	preading. Daugi	nter visits as often as				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		155571	B. WIN			06/03/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			11563 V	WEST 300 SOUTH		
	S MERRY MANOR			DUNKI	RK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	can.						
	Goals: Resider	nt will have no s/s					
	(signs and sym	ptoms) of mood					
	decline. To sho	ow physical sign stress					
	is being alleviat	ted. Carry on					
	_	ther than self. Accept					
		cation as prescribed.					
		olved with self initiated					
	activities of cho	ice. Will encourage					
	two group activ						
	Supervised out	-					
	weather permit						
	weather permit	3 .					
	Interventions: I	Discuss feelings about					
		_					
	· •	resident. Discuss					
		er and options of					
		anneling of these					
	_	sident. Encourage					
		eep in contact/visit as					
	much as possib	_					
		ress feeling. Give					
	•	per physician orders.					
		status/mood state					
	changes as nee	eded. Provide					
	emotional supp	ort to resident and or					
	family as neede	ed. Assist with outdoor					
	events as weat	her and health permits.					
	Offer groups ar						
	participation for	_					
		Offer in room activities.					
		s. Provide assistance					
		ovide independent in					
	room activities	-					
	100111 activities	ao roquesteu.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155571	B. WING		06/03/2011
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	ı	ADDRESS, CITY, STATE, ZIP CODE	
MILLEDI	S MERRY MANOR		l l	WEST 300 SOUTH	
				RK, IN47336	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		re plan for activities,	1710		DATE
	dated 5/31/201	•			
	dated 5/51/201	i, illoiddca.			
	Focus: Feelings of sadness,				
		riety, uneasiness,			
	depression cha	•			
	I	ng, low self esteem,			
	tearfulness, mo	•			
		n care/activities related			
	to: relocation.				
	Prefers to stay	in room and not attend			
	group activities	. Resident is hard of			
	hearing, reads	some lips, and enjoys			
	reading. Daug	hter visits as often as			
	can.				
		nt will have no s/s			
	` •	ptoms) of mood			
		ow physical sign stress			
	is being allevia				
		ther than self. Accept			
		cation as prescribed.			
		e satisfied with self			
		es, will encourage two			
		monthly of choice,			
		ts one time weekly, and			
	1	door wheelchair door events as weather			
	permits.	JUUI EVEIIIS AS WEALIIEI			
	perinis.				
	Interventions:	Discuss feelings about			
		resident. Discuss			
	l •	er and options of			
	"	anneling of these			
		sident. Encourage			
	<u> </u>		<u> </u>	!	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/03/2011	
	PROVIDER OR SUPPLIER		STREET A 11563 V	ADDRESS, CITY, STATE, ZIP CO VEST 300 SOUTH RK, IN47336	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE COMPLE	TION
	much as possit resident to exp medication as p Monitor mental changes as needed events as weat Offer groups ar participation for socialization. Oralise all effort as needed. Proroom activities Review of the affrom 3/1/11 through the Activity Directory in an outside been in an outside been in an outside period of time, attendance logindicated the regroup activities month, and her room/individual weekly visits to occasional refroroom.	port to resident and or ed. Assist with outdoor her and health permits. Indencourage representation in the increased of the resident in the ector on 6/2/11 at 2:00 desident only attended once or twice a reweekly in activities included the beauty shop and eshments served in her resident served in her residents activities included the beauty shop and eshments served in her residents activity and activities included the beauty shop and eshments served in her residents and activities included the beauty shop and eshments served in her residents activities included the beauty shop and eshments served in her residents activities included the beauty shop and eshments served in her residents activities included the beauty shop and eshments served in her residents activities included the beauty shop and eshments served in her residents activities included the served in her residents activities activities in the residents activities activ				
	but was not lim	arterly activity ated 3/7/11, included, ited to: "has little p activities, prefers to				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155571	B. WIN	G		06/03/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
MILLEDIS	S MERRY MANOR			1	WEST 300 SOUTH	
					RK, IN47336	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		Has breakfast in dining	+	1110		DATE
ı	1	portive family, visits				
	when can. Has been going through					
		dical treatments lately.				
		cult to read. Added				
	supervised out	door events as weather				
	permits to her	care plan."				
		activity care plans had				
	no additional re					
		address the resident's				
	l '	emain in her room in				
		her refusal to attend				
		s, and her recent				
	magazines.	y to read books and				
	magazines.					
	An interview wi	th Resident # 21 on				
		PM, indicated she is				
		and cannot attend				
	activities on he	r own." She indicated				
	she was not aw	vare of any activities				
	available in the	evening or on				
	· ·	could not attend them				
	'	cannot get out of her				
		cated "they bring me				
	books to read."	1				
	A falla	maiores established				
	•	erview with Resident				
		at 1:30 P.M., indicated				
		to go outside more ather was nice. She				
		she liked to work with				
	plants.	SHE INCO TO MOLK MILLI				
	Pianto.					
	<u> </u>				l	

000519

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/03/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11563 WEST 300 SOUTH DUNKIRK, IN47336					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	on 6/2/11 at 1:5 tries to have an month if possib Resident #21 reconsistently, bus aid she would more. She indithis resident outransferred back her wheelchair she thought the been outside or summer. The Adocumentation in an outside acporch from 3/1/present. The Aprovide any infoundating the reconsistent in the provide any infoundation in the provide any	ctivity Director failed to promation related to sident's health care the current status and						
F0282 SS=D	facility must be pro in accordance with plan of care.	ded or arranged by the ovided by qualified persons n each resident's written						
	review, and inte failed to provide accordance wit	rvations, record erview, the facility e activities in h the activity care plan residents in a sample	F02	282	It is the policy of Miller Merry Manor, Dunkirk to provious ongoing program of activities designed to meet, in accordance the comprehensive assessment, interests and the physical, mental	de an with	07/03/2011	

li ´		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
		155571	B. WING		06/03/	2011
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COI	DE	
MULEDI			I	33 WEST 300 SOUTH		
MILLERS	S MERRY MANOR		DUN	IKIRK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG			DATE
		nts who met the		and psychosocial well-be resident.	eing of each	
	criteria for activ	ities. (Resident #21).		resident.		
				Resident # 21 has	been	
	Findings includ	e:		offered activities outside	in	
				accordance with her Plan		
	Observations o	f Resident #21		On 6/9, 6/13, 6/14, 6/16,		
	included:			6/21 Resident #21 active		
				participated in outdoor as (Attachment # 9). The A		
		P.M. and 3:10 P.M.:		Director will be responsi		
	The resident wa	as sitting in her room in		document on a daily basi		
	her recliner cha	ir. No reading		activities along with all o		
	material was ob	oserved.		activities provided and/o	r refused.	
				This deficient practice ha		
	6/1/11 at 9:20	A.M.: The resident		potential to affect all other	er residents	
	was sitting in he	er room in her chair		in the facility.		
	with no activity			All activity Care Plans w	rill be	
	ĺ			reviewed by 7/3/11 to en		
	6/1/11 at 1:45 F	P.M., 3:05 P.M., and		accuracy of resident's ne		
		resident was sitting in		concerns, and measurable		
		chair. No reading		being met. Appropriate		
	material was of	•		will be implemented and		
	material was or			certain to be in place and		
	The weather or	itside the facility on		by the interdisciplinary to Care Plans are reviewed		
		unny and warm all day		quarterly basis and with		
		res ranging from the		significant change to a re		
	-	through the mid 80		condition. A QA Tool "C		
	_	/31/2011 and 6/1/2011,		Review" (Attachment #6	*	
	_	ents were observed		completed by the Admin		
		ay in rocking chairs on		designee. This will be co	•	
		neelchairs on the		monthly for 3 months the thereafter. Corrective ac		
	•	ng on facility grounds.		monitored in the monthly		
	porch, or walkir	ig on facility grounds.		meeting and any issues v		
	Dovious of the	linical record for		addressed. Date of Com		
				be 7/3/11.		
	Resident #21 0 	n 6/1/11 at 2:00 P.M.,				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER	!! R	1	11563 V	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	īE.	(X5) COMPLETION
TAG	included an Ac	LISC IDENTIFYING INFORMATION) tivity care plan dated		TAG	DEFICIENCY)		DATE
	depression chaineffective copilitearfulness, more withdrawal from to: relocation. Prefers to stay group activities hearing, reads reading. Daug can.	ciety, uneasiness, aracterized by ang, low self esteem, otor agitation, an care/activities related in room and not attend a. Resident is hard of some lips, and enjoys hter visits as often as					
	(signs and symdecline. To she is being allevia conversation or care and medic Will remain invactivities of che two group activities of che two groups activities activitie	ther than self. Accept cation as prescribed. olved with self initiated bice. Will encourage vities monthly.					
	loved ones to k	keep in contact/visit as ble. Encourage					

		(X2) MULTIPLE CONSTRUCTION (X3) DATE 00 COMPI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155571	A. BUILDING		00	06/03/2	
		100071	B. WING			00/03/2	.011
NAME OF F	PROVIDER OR SUPPLIER		I		DDRESS, CITY, STATE, ZIP CODE /EST 300 SOUTH		
MILLER'S	S MERRY MANOR				2K, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL	PREFI	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	TAG	+	DEFICIENCE!		DATE
	•	ress feeling. Give per physician orders.					
	•	status/mood state					
	changes as nee						
	_	ort to resident and or					
		ed. Assist with outdoor					
	•	her and health permits.					
	Offer groups ar	nd encourage					
	participation for	rincreased					
	socialization. C	Offer in room activities.					
		s. Provide assistance					
		ovide independent in					
	room activities	as requested.					
	The current car	re plan for activities,					
	dated 5/31/201	•					
		,					
	Focus: Feeling	s of sadness,					
	emptiness, anx	iety, uneasiness,					
	depression cha	racterized by					
	ineffective copi	ng, low self esteem,					
	tearfulness, mo	_					
		n care/activities related					
	to: relocation.	Samuel and a second as the					
	•	in room and not attend					
	•	. Resident is hard of					
	_	some lips, and enjoys					
	can.	hter visits as often as					
	can.						
	Goals: Reside	nt will have no s/s					
		ptoms) of mood					
	` ` `	ow physical sign stress					
	is being alleviat	ted. Carry on					
	conversation ot	ther than self. Accept					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155571	B. WIN			06/03/2	011
		I	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	VEST 300 SOUTH		
MILLER'S	S MERRY MANOR				RK, IN47336		
		TATEMENT OF DEFICIENCIES			,		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	, i	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	+	IAG			DAIL
		cation as prescribed.					
		e satisfied with self					
		es, will encourage two					
	• ·	monthly of choice,					
		ts one time weekly, and					
	· ·	door wheelchair					
		door events as weather					
	permits.						
	Interventions:	Discuss feelings about					
	placement with	resident. Discuss					
	feelings of ang	er and options of					
	appropriate cha	anneling of these					
	'''	sident. Encourage					
	_	keep in contact/visit as					
		ble. Encourage					
	•	ress feeling. Give					
		per physician orders.					
	l '	status/mood state					
	changes as ne						
	•						
		oort to resident and or					
		ed. Assist with outdoor					
		ther and health permits.					
	Offer groups a	•					
	participation fo						
		Offer in room activities.					
		s. Provide assistance					
		ovide independent in					
	room activities	as requested.					
	Review of the A	Activity Attendance					
	Logs from 3/1/	11 through the present					
	with the Activity	Director on 6/2/11 at					
	l -	cated the resident had					
	· ·	outside activity during					

	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE: COMPL 06/03/2	ETED
	PROVIDER OR SUPPLIER	8	1.	1563 W	DDRESS, CITY, STATE, ZIP CODE /EST 300 SOUTH IK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	activity attendated indicated the regroup activities month, and her room/individuate weekly visits to	me. The resident's ince logs for this period esident only attended sonce or twice a reweekly in I activities included the beauty shop and eshments served in her					
	but was not liminterest in groustay in room. Has surwhen can. Has some extra me Little more diffi	ated 3/7/11, included, lited to: "has little p activities, prefers to Has breakfast in dining portive family, visits been going through dical treatments lately. Cult to read. Added door events as weather					
	5/31/11 at 2:45 "is chair bound activities on he she was not avavailable in the weekends, but anyway as she	could not attend them cannot get out of her cated "they bring me					
	•	erview with Resident at 1:30 P.M., indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 11563 V	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	often if the wea	to go outside more other was nice. She othe liked to work with					
	Director on 6/2 indicated she to activity twice a indicated Residurity consistent had said she with more. She indicated this resident outransferred back her wheelchair she thought the been outside of summer. The Adocumentation	th the Activity Director /11 at 1:50 P.M., ries to have an offsite month if possible. She lent #21 refuses these ly, but the resident ould like to go outside cated they had to take itside before she was ek to her recliner from in the morning, and resident had only he time this spring and Activity Director had no the resident had been civity or outside on the /11 through the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/03/2011
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			11563 V	ADDRESS, CITY, STATE, ZIP CODE NEST 300 SOUTH RK, IN47336	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug without adequate the presence of acindicate the dose discontinued; or a reasons above. Based on a compresident, the facilit residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to discontinued; observation, are failed to ensure received adequated in the residents who use gradual dose reduinterventions, unlein an effort to discontinued to ensure received adequated in the residents who use gradual dose reduinterventions, unlein an effort to discontinued to ensure received adequated to ensure received adequated to ensure received adequated to the residents of the ath concerns reviewed for medications or reviewed for medications are reviewed for medications or reviewed for medications are reviewed for medications.	late monitoring for dered by the physician behaviors and/or for 3 of 10 residents edication monitoring in the physician ble of 24. (Resident	F0329	F 329 It is the policy of Miller Merry Manor, Dunkirk that eac resident's drug regimen must be from unnecessary drugs. An unnecessary drug is any drug w used in excessive dose (includin duplicate therapy); or for exces duration; or without adequate monitoring; or without adequate adverse consequences which in the dose should be reduced or discontinued; or any combination	h e free then ng sive e dicate

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155571	B. WIN			06/03/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t		1	VEST 300 SOUTH		
MILLER'	S MERRY MANOR			1	RK, IN47336		
				(10, 11047 550			
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TΕ	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG			DATE
	Findings includ	e:			the reasons above.		
					Resident # 41: The resident rec	and	
	1.) The clinical	I record for Resident			has been reviewed. Diagnosis		
	#41 was reviev	ved on 6/1/11 at 2:30			essential tremors has been adde		
	p.m.				Pharmacy has reviewed the	u.	
					medication. The physician has		
	Diagnoses for	Resident #41 included,			provided documentation for the	use	
	1 -	nited to, cerebral artery			of the medication and the care p	olan	
		infarction, diabetes			has been reviewed and updated.		
					Resident # 30: Care Plan has be		
	mellitus, essential tremors, and congestive heart failure.				reviewed and updated to include		
	congestive nea	irt lallule.			non-pharmacological interventi		
	Current physician's orders, signed				for increased anxiety. Behavior tracker is in place.	r	
					Resident # 50: Resident has be	en	
	· ·	ed Resident #41			discharged from the facility.	CII	
		done 50 milligrams			discharged from the facility.		
	(mgs) 1 tablet a	at 8 a.m. daily and 2			All resident's have the potential	to be	
	tablets (100 mg	g) at 8 p.m. daily.			affected by this deficient practic		
					All residents receiving anti-psy	chotic	
	The 2012 Nurs	ing Drug Handbook			medication will be reviewed to		
	indicated this n	nedication was an			ensure appropriate monitoring i	s in	
	anti-seizure me	edication. The clinical			place for drug side effects and	1.0	
	record lacked a	any diagnosis of			appropriate diagnosis is indicate use. Behavior trackers will be	ed for	
		for Resident #41.			reviewed and updated as well as	s the	
					resident's plan of care.	5 and	
	During an inter	view on 6/2/11 at 3:40			r		
	_	tor of Nursing (DON)			The following measures will be	in	
	1 '	• ,			place to ensure this deficient pra	actice	
		ad found the original rimidone medication			does not recur.		
		ered for the essential			1. The facility will ensure al		
		ndicated Resident #41			medication has diagnosis to sup	port	
		with tremors of his left			use. 2. All residents receiving		
	leg.				All residents receiving psychotropic medications will be	ne l	
					monitored for potential side effor		
	The 2012 Nurs	ing Drug Handbook			related to the medication.		
	indicated the th	nerapeutic dose of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER		•	11563 W	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	monitoring Printange between laboratory reportance on 10/8/10 resident's level. The resident with 100 mg twice with level was taken decreased to the mg in the a.m. on 4/7/11. The dated 4/7/11, in staff was to contany increase in clinical record. I level testing information the one drawn. The clinical record is level testing information that the one drawn. The clinical record is level testing information and increased trem. A 4/12/11 at 1:3 indicated "no ir noted." The climonitoring information increased trem.	was 5.9 on that date. as receiving Primidone when that Primidone in. That dose was ne current dose of 50 and 100 mg in the p.m. is physician's order, indicated the nursing intact the physician for a tremors noted. The acked any Primidone formation other than on 10/8/10. Ford lacked any health related to the resident ins with essential seed for possible ing of the Primidone d/or the need to effects of the dany problems with			3. Behavior trackers will ref resident specific behaviors and include non-pharmacological interventions. 4. Monthly medication reviewill be completed by the Consupharmacist (last completed 6/6/5. Monthly behavior meeting Interdisciplinary Team and Consultant Pharmacist will be completed to ensure appropriate reduction recommendations are addressed. 6. Staff will be reeducated regarding interventions for behamanagement and required documentation. The corrective action for this deficient practice will be monitutilizing the QA Tool "Behavio Antipsychotic Medication Revi (Attachment #8). This will be completed monthly for the next months and quarterly thereafter the Director of Nursing or design This QA Tool will be reviewed the QA team in the monthly QA meeting. Date of Compliance vi 7/3/11.	will will wiltant (11) g with e drug avior ored r & ew" 3 by gnee. by	

000519

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155571		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE: COMPL 06/03/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH RK, IN47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
TAG	During an obset 11:20 a.m., Reshis wheelchair room. A contining the resident's During an interior of Nursing (DO on 6/3/11 at 10 information was the lack of mon Primidone med any health care the resident's difference. The Ephysician had reprimidone leve was decreased low dosage of the was given for enot for seizure. The facility faile additional inform 6/3/11. 2. Resident #50' reviewed on 6/2/	ervation on 6/3/11 at sident #41 was up in in the doorway of his uous tremor was noted is left leg. View with the Director N) and Administrator (15 a.m., additional is requested regarding itoring related to the ication and the lack of eplanning related to iagnosis of essential DON indicated the not ordered any further is after the medication on 4/7/11 due to the he medication which is sential tremors and activity. End to provide any mation as of exit on seclinical record was 11 at 12:56 p.m.		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155571	B. WIN			06/03/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MILLER'S MERRY MANOR				VEST 300 SOUTH RK, IN47336			
		TATEL IENT OF DEFICIENCIES		L	(1, 11 47 000		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	retention.		İ				
	The resident's ph	ysician's orders were					
	signed on 5/26/1	1. The resident had a					
	5/22/11, Physicia	an's order for Klonopin					
	0.5 mg one every	six hours prn [as					
	needed] for anxie	ety.					
	The resident had	a 5/22/11, admission					
	Minimum Data S	Set [MDS] assessment					
	indicated the resi	ident had no memory					
	problems.						
		ay, 2011, Medication					
		Record indicated the					
		l clonazepam (generic					
		g seven times between					
		. The record lacked any					
	indication of non	-					
	interventions atte	empted prior to use.					
		1 1 5 200 /11					
		note, dated 5/20/11 at					
	l '	ated Resident #50's					
	1 * *	otified for a request of					
		every 6 hours prn for					
		e resident indicated she					
	was on this medi	cation prior to					
	admittance.						
	The resident had	a 5/25/11 Care Plan					
		tial for side effects of					
		dication characterized by ardiac, neuromuscular,					
	1 ^	ystems as evidenced by:					
	gasironnesiniai s	ysicilis as evidenced by.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
ANDILAN	OF CORRECTION	155571	A. BUI		00	06/03/2	
		100071	B. WIN		PRESIDENCE CONTROL CON	00/03/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH		
MILLER'S	S MERRY MANOR			1	RK, IN47336		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hypotension, dizz	ziness, syncope, unsteady					
	gait/balance, or c	lecline with Activities of					
	Daily Living. Th	ne interventions for this					
	focus were:						
	Administer m	edications as ordered.					
	2. Evaluated effo	ectiveness and sided					
	effects of medica	ations daily.					
	3. Notify Medica	al Doctor or psychiatric					
	physician as need	ded.					
	The resident had	a 5/17/11, Care Plan					
	Focus of: Resident is at risk to experience						
	mood problems r	related to placement in an					
	extended care fac	cility until therapy feels it					
		return home. The					
	interventions for	this problem were:					
		nt to verbalize fears or					
	concerns.						
	2. Listen attentiv	vely and follow-up on					
	issues prn.	,					
		ort and encouragement					
	prn	S					
	•						
	During an intervi	iew with the Director of					
	~	1 at 2:44 p.m., she					
	_	ident had been on					
		e and had recently					
	_	an so the medication had					
	1	the resident's request.					
	3. Resident #30'	s clinical record was					
	reviewed on 6/1/	11 at 2:25 p.m.					
	The resident's dia	agnoses included, but	\perp				

000519

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CO	NSTRUCTION 00	COMPL	ETED	
		155571	B. WIN			06/03/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE VEST 300 SOUTH		
MILLER'S	S MERRY MANOR			1	RK, IN47336		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	were not limited	to, dementia; diabetes					
	mellitus; hyperte	nsion; macular					
	degeneration of t	he retina.					
	1	ysician's orders were on 5/17/11. The resident					
	~	Xanax [an anti-anxiety					
		ng tablet, give one half					
		eight hours as needed for					
	anxiety related to	dementia.					
		1/0/11					
		a 4/3/11, admission					
		t. The assessment dent had short term					
	memory problem						
	inemory proores.						
	Review of the M	edication Admission					
	Record indicated	the resident received					
	1	on 3/25/11 at 8:30 a.m.,					
	1	.m., and 4/8/11 at 10:00					
	l '	ed anxiety. The record					
	lacked an indicat	ical interventions used					
	prior to the admi						
	medication.	monution of the					
		sident's clinical record					
		ons to be used prior to					
	the administratio	n of Xanax.					
	A 4/8/11, 3:54 a.:	m., progress note					
	indicated the resi						
		d several times this shift.					
	She is wanting to	call her daughter to go					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTR		(X3) DATE S COMPL		
		155571	B. WING	_		06/03/2	011
	PROVIDER OR SUPPLIER		115		ESS, CITY, STATE, ZIP CODE T 300 SOUTH N47336		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	home. Several at were unsuccessfu	ttempts at redirection					
	p.m., the Social S the resident's beh on the Medicatio She indicated the behavior progran	Service Director indicated naviors were documented n Administration Record. The resident was not on a n. She indicated the emergency admission for tia.					
	the Director of N resident fell at he The resident's da resident Xanax 0 admission. The I indicated the resion 3/25/11 and ir receive Xanax. Standaughter frequen	9:14 a.m., interview with fursing she indicated the ome prior to admission. ughter was giving the .5 mg bid. prior to Director of Nursing dent's daughter was here asisted the resident She indicated the tly requested the Xanax ue to the resident being					
	dated 5/3/6, titled Policy," provided at 12:43 p.m., ind limited to, the for "*Use of the Addrugs should occ	e current facility policy, d "Psychotropic Drug Use d by the DoN on 6/2/11, cluded, but was not llowing: nxiolytic or sedative ur only when: Evidence ossible reasons for the					

l	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	ľ í	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER		11563 V	ADDRESS, CITY, STATE, ZIP CO VEST 300 SOUTH RK, IN47336	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	use results in a n in the residents f	has been ruled out and naintenance improvement functional status as medical record				
	1. When using anxiolytic, sedate will be quantitated monitored daily, monitored are the resident to represent the sort cause t	R MONITORING: ag an antipsychotic, ive or hypnotic, behaviors vely and objectively Specific behaviors to be ose which cause the sent a danger to self or the resident distress and anctional capacity. (see then the sent and management				